MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Texas Imaging & Diagnostic Center 3840 W NW Hwy Ste 400 Dallas, TX 75220	MDR Tracking No.: M4-03-8367-01
Respondent's Name and Address Liberty Mutual Fire Insurance 2875 Browns Bridge Road Gainesville, GA 30504 Box #28	Employer's Name: Autozone, Inc. Insurance Carrier's No.: 949686210

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
12/06/02	**1/03/03**	**99070-ST**	**$357.82**	**$357.82**

PART III: REQUESTOR'S POSITION SUMMARY

The Requestor's position statement states in part, "…The Lumbar Epidural Steroid Injection falls under Surgical Procedures Performed in a Doctor's Office. We meet all the requirements listed under this guideline in order to bill and be paid for this code…"

PART IV: RESPONDENT'S POSITION SUMMARY

Liberty Mutual reimbursed Texas Imaging and diagnostic Center $100.00 for the sterile tray on 12/06/02 and $100.00 for the sterile tray on 1/3/03. The fair and reasonable reimbursement is less that the doctor's usual charge…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The Requestor billed $278.91 for CPT code 99070-ST for each date of service. The Carrier reimbursed $100.00 for each date of service. The Carrier denied additional reimbursement as "F – Z560 The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix."

CPT code 99070-ST is a DOP procedure code and has no MAR. The Requestor submitted documentation in accordance with the 1996 MFG, Surgery Ground Rule (V)(A) and (B)(1), to support the charges as billed. The Requestor has also provided redacted sample EOBs as evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. On this basis, reimbursed is recommended in the amount of $357.82.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
12/6/2002	99070-ST	$178.91	$178.91				
1/3/2003	99070-ST	$178.91	$178.91				
					Total Left Column:		$357.82
					Total Amount Due:		$357.82

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$357.82**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	January 31, 2005 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____